Commonwealth of Massachusetts
Executive Office Health and Human Services

RY2021 EOHHS Manual Release Notes (Version 14.1)

Supplement to:
RY2021 EOHHS Technical Specifications Manual for Acute Hospital Quality Measures (v14.0)

Published: November 12, 2020

Introduction

A. Purpose

The purpose of EOHHS Release Notes is to provide hospitals participating in MassHealth Acute Hospital Pay-for-Performance (P4P) Program with updates to quality reporting requirements in the RY2021 EOHHS Technical Specifications Manual contents posted on Mass.Gov website. This document lists the important updates and their impact on data collection and reporting requirements.

1) **Important Update:** Based on hospital stakeholder input, MassHealth has taken steps to harmonize the care coordination measure set (CCM-1, 2, 3) data specifications with the CMS inpatient psychiatric facility quality reporting (IPFQR) care transition measures and the Joint Commission standards. The MassHealth specifications were modified based on consensus that changes be applicable to the broader inpatient patient population described in Section 2.B of EOHHS Technical Specifications Manual (14.0). Changes to upcoming quality reporting requirements are provided with sufficient notice to allow hospitals ample time for implementation.

2) **Changes to Data Specifications:**
   a. **Reconciled Medication List (CCM-1)**: Update data dictionary definition to require that each medication include an intended duration or an indication to continue medication until told to stop.
   b. **Transition Record Received with Specified Data Elements (CCM-2):** Update data dictionary definition for Advance Care Plan data element to remove reference to DNR and full code status to meet measure.
   c. **Timely Transmittal of Transition Record (CCM-3):** Addition of a new patient refusal data element. If there is documentation of patient refusal of transmission the case may be excluded.

3) **Effective Date:** Changes to data reporting requirements are effective with calendar year Q3-2021 reporting cycle (July 1, 2021 to September 30, 2021 discharges).

B. EOHHS Manual Versions

a) This EOHHS Release Notes version document should be used in conjunction with the RY2021 EOHHS Technical Specifications Manual (v14.0).
b) Hospitals are responsible for downloading and using the appropriate versions of EOHHS Manual and Appendix data tools that apply to each quarterly discharge data period being collected and submitted. Failure to adhere to appropriate versions of the data collection tools will result in MassQEX portal rejecting data files.

C. Guidelines for Using Release Notes

The Release Notes are organized to follow the EOHHS Technical Specifications Manual sections and appendices in the table of contents. Updates are presented using the following headings:

- **Key Impact** – identifies the EOHHS Manual section that is impacted by the change listed (i.e.: measure specifications, data tools, dictionary, etc.). A key impact is defined as information that will substantively affect data collection and reporting file requirements.
- **Description of Change** – identifies the specific content within the manual section where the change was made. (i.e.: measure specifications, flowcharts, data format, reporting values, etc.).
- **Rationale** – a brief statement on the reason why the change is being made.

Contact EOHHS at masshealthhospitalquality@mass.gov if you have any questions about the contents of this Release Notes document.

Section 1: Changes in Release Notes (v 14.1)

This section describes the key impact, description of change and rationale for the updated requirements.

A. Measure Specifications Update. The changes applicable to MassHealth Care Coordination Measures (CCM-1, 2, 3) specifications and related appendix tools are summarized in the table that follows.

Table A – Summary of Changes to Measure Specifications

Key Impact	Description of Change	Rationale
Section 3.C.3: Transmission of Transition Record	• Update CCM-3: Modify flowchart to add data element "Patient Refusal of Transmission". Value of Yes yields exclusion to CCM 3 measure. Value of No yields continue to Transmission Date data element.	• Harmonize specification with the Joint Commission requirements on patient rights to privacy.
Appendix A-3: Data Abstraction tool	• Update CCM-3: Addition of question "Is there documentation in the medical record of patient refusal of transmission to the next site of care, physician, or other health care professional designated for follow-up care?". This will be inserted as Question 28.	• Clarify abstraction tool questions to capture new patient refusal specification.
Appendix A-4: XML Schema MassHealth Specific File	• Update CCM-3: Addition of Patient Refusal of Transmission data element and field requirements.	• Ensure new patient refusal data element is added to file requirement.
Appendix A-6: MassHealth Data Dictionary	• Update CCM-1: Reconciled Medication List to require duration for all medications or a blanket statement indicating that the patient should continue the medications until told to stop. • Update CCM-2: Change advance care plan (ACP) data element definition to remove DNR and Code Status from allowable values. • Update CCM-3 Addition of new Patient Refusal of Transmission data element definition.	• CCM-1: Harmonize definition with CMS-IPFQR care transition record current medication list data element. • CCM-2: Update ACP element consistent with state/federal definitions. Harmonize element with CMS-IPFQR definition as applicable to broader medical/surgical patient population. • CCM-3: Clarify definition applicable to the MassHealth measure.
Appendix A-7: MassHealth Measure Calculation Rules	• Update CCM-3 rules: Insert new row 16 for Patient Refusal of Transmission. Calculation rule states "If value = Y, assign to Category B/ assign to Category X if missing or no match"	Ensure evaluation of patient refusal data element is reflected in measure calculation rules

B. Appendix Tool Versions: Updates to data tools versions in Table 2.4 of EOHHS Technical Specifications Manual (14.0) that apply as of CY2021 are summarized in the table that follows.

Table B: CCM Appendix Data Tool Versions (for CY2021)

Appendix	Data Tool Name	Q1-2021 discharges	Q2-2021 discharges	Q3-2021 discharges
A-3	Data Abstraction Tool (CCM-1,2,3)	v14.0	v14.0	**v14.1**
A-4	XML Schema MassHealth Specific Files	v14.0	v14.0	**v14.1**
A-6	MassHealth Data Dictionary	v14.0	v14.0	**v14.1**
A-7	Measure Calculation Rules	v14.0	v14.0	**v14.1**

Please Contact the MassQEX Help Desk massqexhelp@telligen.com or (844) 546-1343 for all questions regarding upcoming changes to care coordination data reporting specifications.

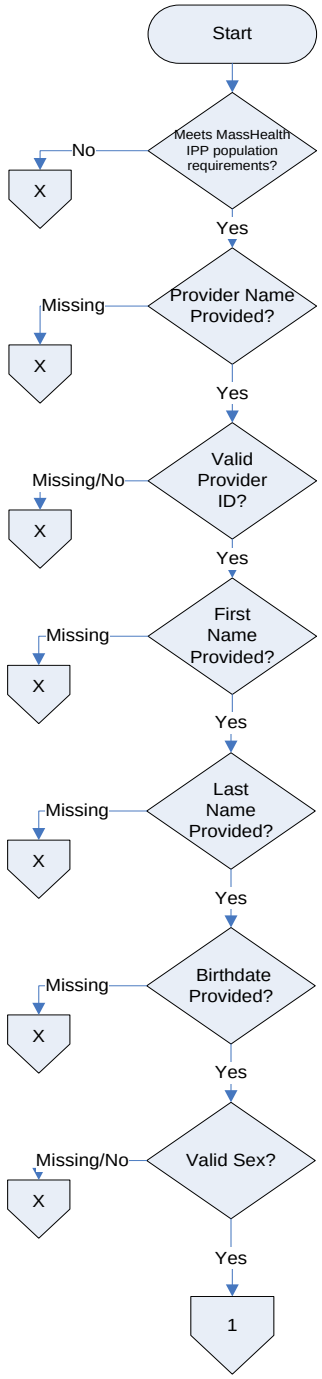
Section 2: Updates to RY21 EOHHS Manual Components

A. Section 3.C-3: Timely Transmittal of Transition Record Measure Flowchart

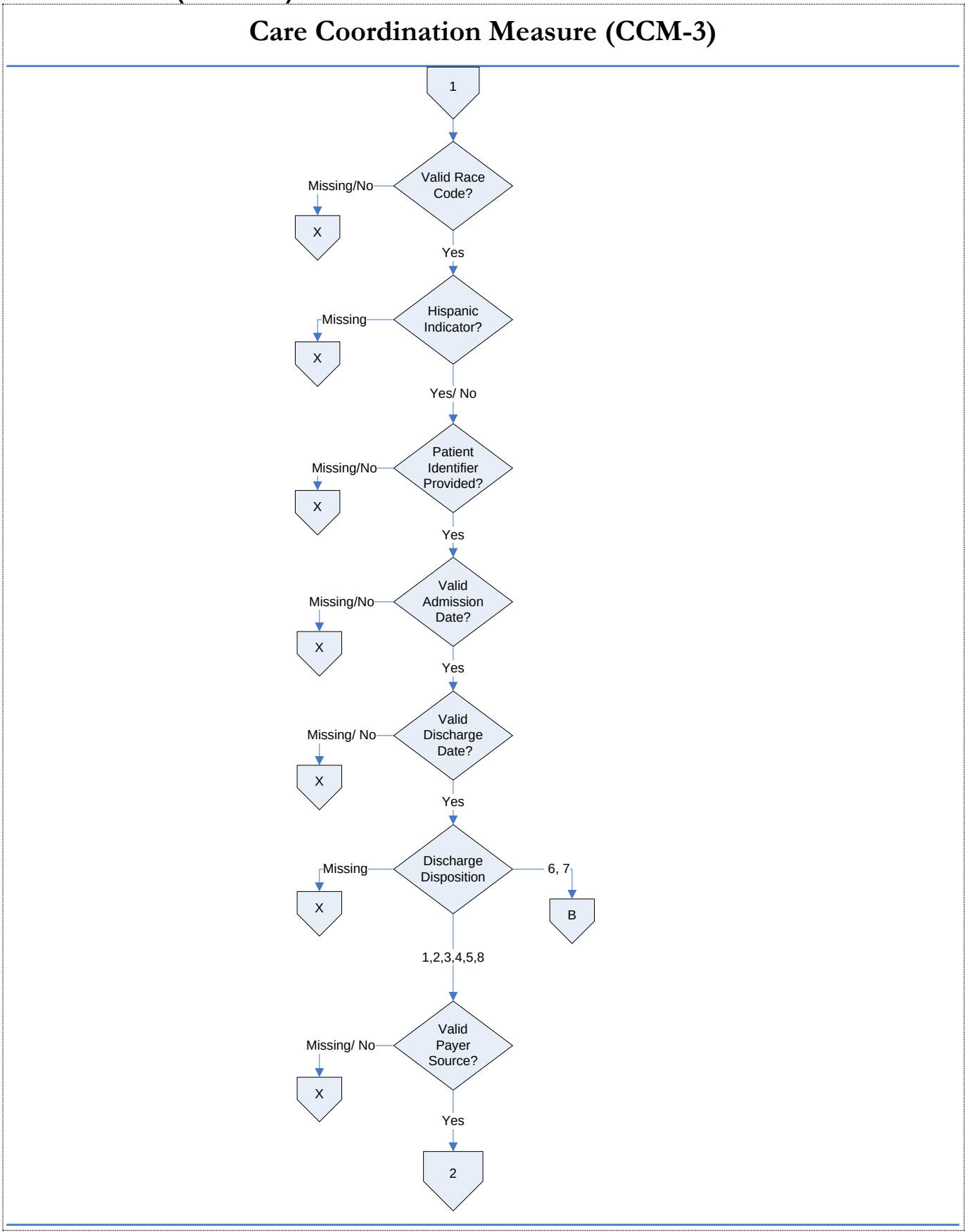
Care Coordination Measure (CCM-3)

***Numerator:** Patients for whom a written transition record was transmitted to the facility or primary physician or other health care professional designated for follow up care within 2 days of discharge

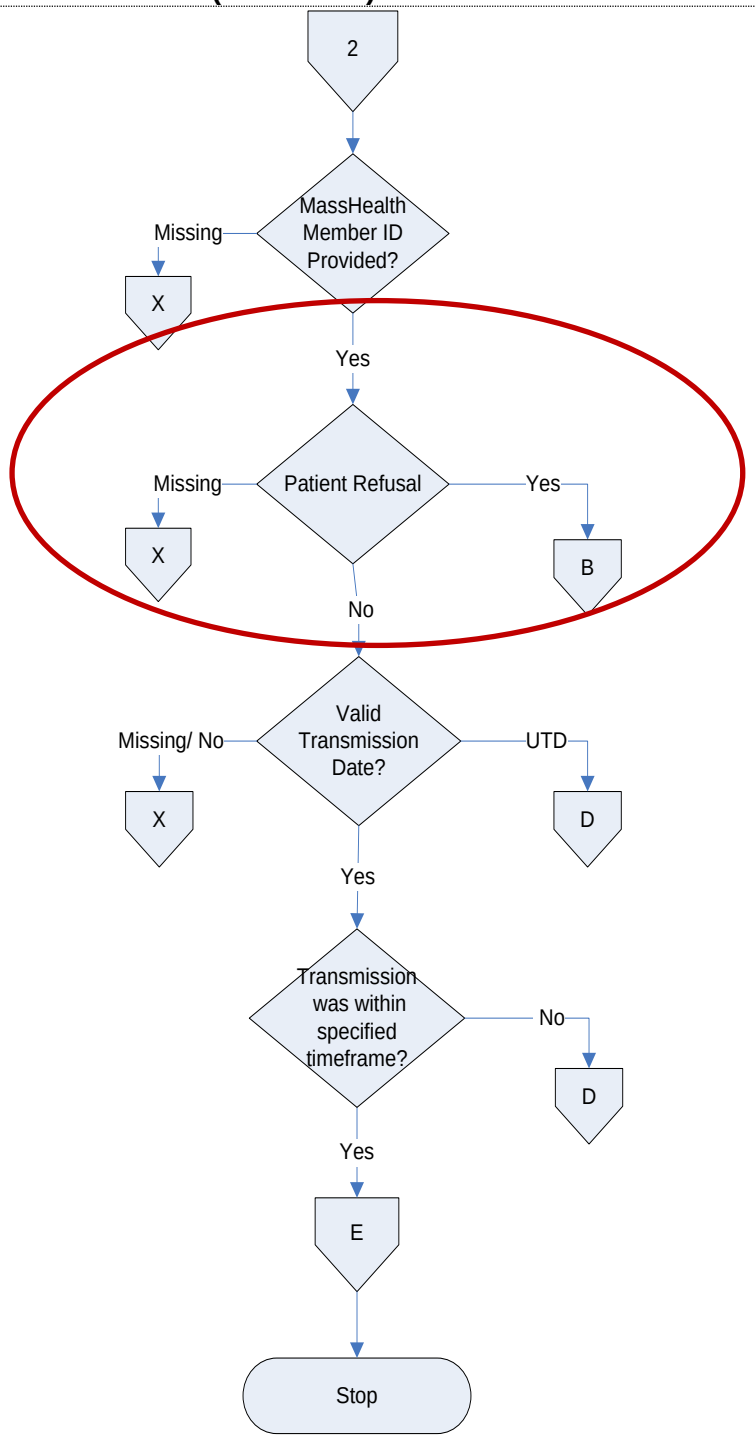
***Denominator:** Patients discharged from an inpatient facility to home/ self care or any other site of care.

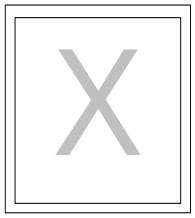


CCM-3 Flowchart (Continued)

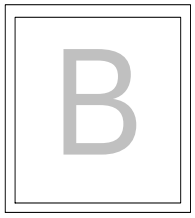


CCM-3 Flowchart (Continued)

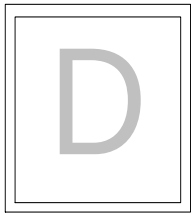




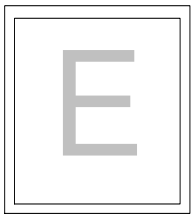
Review Ended
Not in Measure Population
Missing or Invalid Data
Case will be Rejected



Review Ended
Not in Measure Population
Excluded from Numerator and Denominator



Review Ended
In Measure Population
Excluded from Numerator
Included in Denominator



Measure Met
In Measure Population
Included in Numerator and Denominator

Note:
If the Transition Record was transmitted within 2 days of the discharge date, the case will be assigned to Category E.

B. **MassHealth Data Dictionary (Appendix A-6)**

1) **Update to CCM-1:** the following excerpt to the reconciled medication list data element illustrates where changes (in italic underline) apply to the notes for abstraction:

Data Element Name: Reconciled Medication List
Collected For: CCM-1

Notes for Abstraction: Prescribed dosage, instructions, and *intended duration* must be included for each continued and new prescription and non-prescription medication.

A generalized statement regarding intended duration, such as a blanket statement indicating that the patient should continue the medications until told to stop, would be acceptable for routine medications.

2) **Update to CCM-2:** the following excerpt to the advance care plan data element illustrates where text is removed (underline strikethrough) in the definition, notes for abstraction, and guidelines for abstraction table**.**

Data Element Name: Advance Care Plan
Collected For: CCM-2

Definition: An Advance Care Plan refers to a written statement of patient instructions or wishes regarding future use of life sustaining medical treatment. An Advance Care Plan may include: an advance directive, living will, healthcare proxy or surrogate decision maker, ~~DNR~~, or power of attorney.

Notes for Abstraction: The presence of an advance care plan must be documented on the transition record for all patients 18 years and over.

A checkbox or documentation of the presence of an advance directive, health care proxy, surrogate decision maker, power of attorney, ~~DNR or Full Code status~~ etc. must be documented.

Guidelines for Abstraction:

Inclusion	Exclusion
Advance Directive Power of Attorney Health care proxy ~~Do Not Resuscitate – DNR etc~~ Living Will ~~Documentation of code status: Full Code~~ Medical Orders for Life-Sustaining Treatment (MOLST)	Patients < 18 years of age

3) **Update to CCM-3:** the full definition of the new patient refusal data element follows.

Data Element Name:	**Patient Refusal of Transmission**
Collected For:	CCM-3
Definition:	Documentation in the medical record of the patient's or caregiver's refusal of transmission of the patient's healthcare information to include the Transition Record to the next site of care, physician, or other health care professional designated for follow-up care.
Suggested Data Collection Question:	Is there documentation in the medical record of patient refusal of transmission to the next site of care, physician, or other health care professional designated for follow-up care?
Format:	**Length:** 1 **Type:** Alphanumeric **Occurs:** 1
Allowable Values:	Y (Yes) The medical record includes documentation of patient refusal of transmission to the next site of care, physician, or other health care professional designated for follow-up care. N (No) The medical record does not include documentation of patient refusal of transmission to the next site of care, physician, or other health care professional designated for follow-up care.
Notes for Abstraction:	Patient refusal of transmission of the transition record may occur at any point during the inpatient stay. Documentation requirements may be met by the following: • patient signature indicating refusal of transfer of medical record information • nursing note stating patient refusal • other health care provider documentation of refusal -TRANSFER- In the event the patient is transferred to another site of care where the plan for follow-up care will be determined at the time of discharge from that site, patient refusal is abstracted as No. The discharge date should be used as the Transmission Date. Documentation of the discharge date also applies to patients discharged and admitted within the same site.
Suggested Data Sources:	Admission Consent Forms Nursing notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None